A Descriptive Study of the Head Start Health Component

Volume I: Summary Report

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LIST OF EXHIBITS

LIST OF ABBREVIATIONS

Abbreviation	Unabbreviated Term
AAP	American Academy of Pediatrics
ACF	Administration for Children and Families
ACIP	Advisory Committee on Immunization Practices
ACYF	Administration on Children, Youth, and Families
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
AIDS	Acquired Immunodeficiency Syndrome
AOA	American Orthpsychiatric Association
CAA	Community Action Agency
CACFP	Child and Adult Care Food Program
CDA	Child Development Associate
CDC	Centers for Disease Control and Prevention
CDF	Children's Defense Fund
CDM	The CDM Group, Inc.
CPR	Cardiopulmonary Resuscitation
DBP	Diastolic Blood Pressure
DHHS	Department of Health and Human Services
DPT	Diphtheria, Pertussis, and Tetanus
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
FY	Fiscal Year
GAO	General Accounting Office
HepB	Hepatitis B
Hib	*haemophilus influenzae* type b
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization

HSAC	Health Services Advisory Committee
HSCOST	Head Start COST System
HSFIS	Head Start Family Information System
HSMTS	Head Start Management Tracking System
IM	Information Memorandum
LPN	Licensed Practical Nurse
mg/dcl	Micrograms/deciliter
MMR	Measles, Mumps, and Rubella
MMWR	Morbity and Mortality Weekly Report
NCHS	National Center for Health Statistics
NHANES II	National Health and Nutrition Examination Survey Phase II
NHIS	National Health Interview Survey
OIG	Office of the Inspector General
OMB	Office of Management and Budget
OPV	Oral Polio Vaccine
OSPRI	On-Site Program Review Instrument
OTA	Office of Technology Assessment
PIR	Program Information Report
PNSS	Pediatric Nutrition Surveillance System
PPS	Probability Proportional to Size
RN	Registered Nurse
SBP	Systolic Blood Pressure
STD	Sexually Transmitted Disease
TANF	Temporary Assistance for Needy Families
TB	Tuberculosis
USDA	United States Department of Agriculture
WIC	Special Supplemental Food Program for Women, Infants and Children

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EXECUTIVE SUMMARY

"The objectives of a comprehensive program should include improving the child's physical health and physical abilities."

Dr. Robert Cooke and the Head Start Panel of Experts, 1965

Overview

A Descriptive Study of the Head Start Health Component was designed to provide a "national snapshot" of how local Head Start programs meet the medical, dental, nutrition, and mental health needs of the children and families they serve. The Head Start Bureau requires this information for the development of policies that will assist programs in responding to the populations of families served and the conditions faced by local programs. This need was noted in both the *Final Report of the Advisory Committee on Head Start Quality and Expansion,* (1993) and the *Head Start Research and Evaluation Report: A Blueprint for the Future* (1990). This descriptive study was undertaken because little current information was available regarding how program procedures address the health conditions that are common among Head Start children, the community health risks faced by families participating in Head Start, and the health resources available in the communities served by Head Start.

The health services provided to or arranged for Head Start children and their families are expected to be comprehensive. In general, the success of the program in the health area has helped identify Head Start as a model for other child service programs (Gomby, Larner, Stevenson, Lewit, and Behrman, 1995).

"[In Head Start] We're teaching them habits they will hopefully carry with them the rest of their life."
-Head Start staff

This Executive Summary and the associated report detail the historical context of the Health Component and the study methodology and includes the descriptive findings regarding three aspects of the Health Component, as noted below.

Content Areas of Study Findings

- **Program Issues**
  - Staffing and Staff Qualifications
  - Linkages with Medicaid and Community Resources
- **Prevention**
  - Immunizations
  - Health Education
- **Health and Health Services Within the Four Health Domains**
  - The Medical Health Domain
  - The Dental Health Domain
  - The Mental Health Domain
  - The Nutrition Domain

Because this study was descriptive, this report does not evaluate or judge the quality of individual programs, groups of programs, or the entire sample of participating programs; similarly, it is not intended to report on the compliance of local programs with the Head Start Program Performance Standards. The findings from this study are focused on a set of research questions adapted from the original Request for Proposals (see the Summary of Project Research Questions) and designed to provide a baseline description of Health Component activities and the health status of Head Start children. Based on these findings, several implications are discussed regarding Head Start program practices, and recommendations are made regarding future research activities related to the Health Component.

A Summary of the Project Research Questions

- What are the current procedures used by Head Start grantees to provide or obtain health screenings, examinations, immunizations, referrals and treatment services for enrolled children across the four health domains?
- What are the major health problems and risk factors (perceived and actual) present within the four health domains for children and families enrolling in Head Start?
- How promptly are health screenings, examinations, immunizations, referrals and treatment provided across the four health domains? What is the range of treatments children receive?
- What are the Health Component staffing patterns? What are the staff credentials and training for each position.
- What community resources have Head Start programs utilized to meet the health needs of children and their families across the four health domains?
- How is the cost of health services paid for Head Start children covered ?
- What barriers do families and programs face in attempting to access community and State health services?
- What health education efforts are directed towards children and parents?

The Historical Context of the Health Component

Head Start was created in 1965 to enhance the social competence of preschool children and foster constructive opportunities for communities to work together with low-income families in solving their problems. In the *Recommendations for a Head Start Program* (Cooke, 1965), a Panel of Experts specified that the basic elements of the Head Start program should emphasize health assessments for children and health education for both children and their families.

Recommended evaluations included a medical examination (e.g., physical measurements; nutrition, vision, hearing and speech assessments; and other selected tests as required), a dental examination, and a screening for social or emotional problems. Programs were designed to assure proper immunization of all Head Start children, to assure families that children would receive proper treatment for health conditions, to establish continuity of care for children, to inform families about available community health resources, and to teach families about sound nutrition.

The overall goal of Head Start is to promote social competence among participating children (Zigler, et al., 1994). Social competence is a comprehensive construct that includes the belief that optimal health is an important factor related to successful social and cognitive functioning. This concept of integrated areas of child development continues to draw support in the child development literature (Novello, DeGraw, & Kleinman, 1992). Because impaired health may have adverse effects on the development of social competence, children's health has always been a focus of Head Start and remains a critical aspect of the program over three decades later (Zigler et al., 1994).

"It has started my baby girl on the road of education, opened her eyes to basic truths in life. Taught her to care for herself as well as teaching her aunt and mom how to help her at home."
-Head Start parent

The Function and Organization of the Health Component

In 1975, the Head Start Bureau established Program Performance Standards for each of the major program components: Education, Parent Involvement, Social Services, and Health. Grantees are required to comply with the Program Performance Standards, which are accompanied by non-mandated guidance that elaborates on the intent of the Standards and provides information on how they might be carried out. The overall requirements of the Health Component are summarized below:

- Provide a comprehensive program of health services to assist each child in attaining maximum physical, emotional, cognitive, and social development;
- Promote preventive health services and early intervention; and
- Provide families with the skills, insights, and linkages needed to obtain ongoing health care so that children will continue to receive comprehensive health care after they leave the Head Start program.

> **"I believe our role in regards to health is very important as far as providing services, connecting children to services, and providing education to parents."**
> ***-Head Start staff***

The Health Component is designed to emphasize the importance of health education and the early identification and treatment of health problems. Because many low-income children have limited access to health care services, Head Start programs ensure that each child receives comprehensive health care services across each of the four health domains: medical, dental, mental health, and nutrition. The Head Start Bureau has recently published a comprehensive revision of all the Program Performance Standards (Federal Register, 1996) effective January 1998, and is developing additional strategies for supporting health activities at the local level.

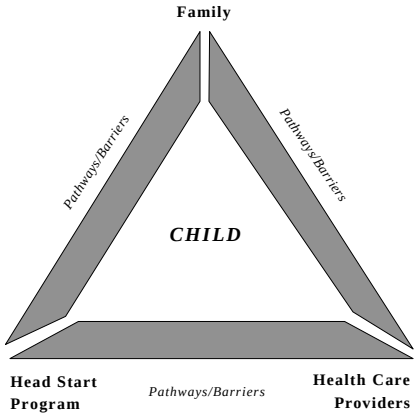
Health Component activities involve virtually all of the Head Start program staff at some point during the program year. The Health Component is managed by a **Health Coordinator** who is responsible for the organization and administration of health services, including medical, dental, mental health and nutrition elements. The Health Coordinator is assisted by, at a minimum, a full-time or regularly scheduled qualified **nutritionist** or **dietitian**, a **mental health professional** (e.g., child psychiatrist, licensed psychologist, psychiatric nurse, or psychiatric social worker) who is available on at least a consultation basis, and a **Disabilities (**or **Handicapped Services) Coordinator** responsible for children with special needs.

The health staff undertake a broker role in the connection between the Head Start parents and community health centers, clinics, and private providers. In this effort, Head Start staff support parents who need to develop the necessary skills to negotiate the health care system themselves. This means enabling parents to make and keep appointments with appropriate service providers in the local community and to obtain follow-up treatment for conditions identified through screenings and examinations. Head Start's objective is for all parents to have the necessary skills to assume responsibility for managing their family's health care after leaving the program.

> **"Basically, we are the hub of the child's health care needs; we are the liaison between the parent, nurse and other health providers."**
>
> ***-Head Start staff***

The parents of Head Start children often face significant barriers to obtaining health care: financial, geographic, and institutional barriers inherent in the community as well as personal and cultural barriers. The health and health care of a Head Start child are influenced by three major resources—the family, the available health care providers, and the Head Start program—as well as the pathways and barriers that affect communication among those support elements. Head Start works to open the pathways between families and health care providers, while also providing families with the knowledge and skills needed to minimize the impact of barriers to accessing quality health care for the child.

Forces Impacting the Health Care of a Head Start Child



Because Head Start does not work as a "stand alone" Federal program, overcoming barriers includes facilitating the use of other Federal programs, such as Women, Infants and Children (WIC) and Medicaid. It became apparent during the study that an important factor in the creation of community linkages is the active integration of Head Start with State and other Federal resources, such as Medicaid, the United States Department of Agriculture (USDA) (i.e., the school lunch program, WIC), and Temporary Assistance for Needy Families (TANF, formerly Aid to Families with Dependent Children). Programs serving low income families are interdependent, and changes in one may affect service delivery in others. Head Start's dependence on other Federal resources is at a point where cuts in other resources would have a serious impact on how local Head Start health staff decide to allocate their limited resources. As noted by the Advisory Committee on Head Start Quality and Expansion:

> We must encourage Head Start to forge partnerships with key community and state institutions and programs in early childhood, family support, health, education, and mental health, as we must ensure that these partnerships are constantly renewed and recrafted to fit changes in families, communities, and state and national policies (p. viii; 1993).

Methodology

This study was designed to collect descriptive data on the Health Component from Head Start staff and parents, and to gather data on the health status of Head Start children from the parents and the Head Start health records. All of the data for this study were collected in the late Spring of 1994, as 4-year-old children were completing Head Start and preparing for entry into kindergarten. Using a national probability sample of Head Start enrollees, a total of 1,189 parent interviews and child health file reviews were completed at 81 centers across 40 programs. The sampling strategy resulted in a nationally representative sample of Head Start families stratified across a range of geographic settings and urban or rural program sites, reflective of the national Head Start profile.

The research staff used nine different data sources at both the program and the center level. The primary staff sources were as follows: Health Coordinator (interview); Nutrition Coordinator (interview); Mental Health Coordinator (interview); Center Director/Lead Teacher (interview); Parent Involvement Coordinator (interview); and Budget Manager (questionnaire). As noted, parents of 4-year-old children (approximately 15 per center/30 per program) were interviewed, the Head Start health files for the children of the interviewed parents were reviewed, and meal observations were conducted at each center. A total of 219 staff interviews were completed and 177 meal observations were conducted. Because of the variations in the Budget Manager reports that were received, these data were not included in this report.

The following sections provide summaries of the key findings from each of the chapters in the study's Final Report. More extensive findings on particular topics are found in Volumes I and II of the Final Report.

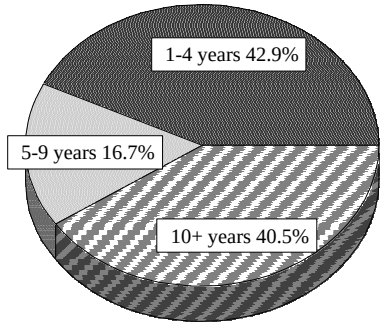
Program Staffing and Staff Qualifications

Head Start staff generally reflect a broad range of backgrounds and qualifications. Program staffing patterns and staff training were reported by staff associated with the Health Component. The highlights of those responses are presented below.

> **"It takes an incredible amount of coordination and commitment by everybody, and it's worth it. We do it because it makes a difference."**
>
> ***-Head Start staff***

- Staff reported working in Head Start for averages ranging from 9 years (Health and Nutrition Coordinators) and 15 years (Center Directors), and reported working in their current positions for between 5 and 6 years.

Number of Years Working at Head Start for Health Coordinators



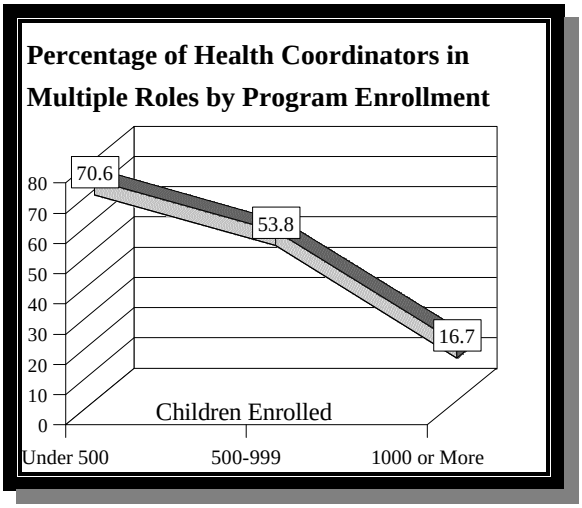
- Staff reported working an average of 5 to 7 hours per week beyond the time for which they were paid.

- About 95% of the interviewed staff reported that their highest level of education was a college degree (or higher) or some college; approximately 40% of the Health Coordinators reported that they had nursing training, and approximately one third of the Mental Health Coordinators interviewed indicated that they had a master's degree. Overall, 64% of the Health Coordinators had either a nursing degree, a Bachelor's degree, or higher.

- Approximately one third of Center Directors and over half of each of the other staff in positions associated with the Health Component reported performing multiple staff roles. Overall, 49% of the interviewed staff were performing multiple roles, with approximately one third of these (34%) reporting that they had been hired to perform multiple roles.

- There is an inverse relationship between program size (based on the total count of children enrolled) and the performance of multiple staff roles.

  Health Component staff in programs with smaller enrollments more often reported performing multiple roles than did staff in larger programs and were generally less likely to have bachelor's or nursing degrees.



Linkages with Medicaid and Community Resources

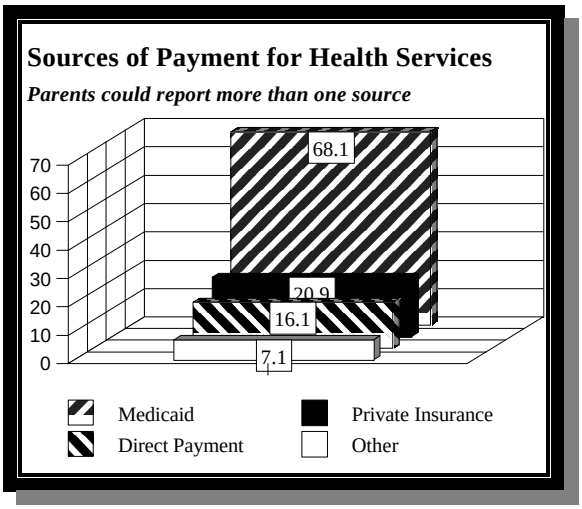
Programs are expected to establish cooperative and responsive relationships with institutions and individual service providers in their local communities. This includes aiding families in exploring available financial resources when assistance is needed to pay for services. The major findings of this chapter are summarized below.

"They gave me names of places I could go for medical care for the boys when the clinic wouldn't see us anymore."

- Head Start parent

- The major types of organizations most commonly reported by Health Coordinators as being associated with their Head Start programs were public health agencies and private group providers. The most often reported services provided were medical services and screenings, vision screenings and eye care, immunizations, dental services, and nutrition services and meal planning.

- Over two thirds of the parents (68%) reported Medicaid as the primary source of payment for health services. Among the Medicaid enrolled children, almost two thirds were enrolled at or near the time of their birth (1988-90) and an additional one fifth became enrolled during the Head Start program year (1993-94).



- Barriers facing families are both personal and community-based. The latter includes the lack of specialists and general health providers in their respective communities. Major personal barriers to care include parents not understanding the need for treatment services, parents' resistance to using services, and the lack of time for parents to access services for their children. Each of these barriers was reported by at least 20% of the programs. The failure of community providers to assist low-income families continues to be a major barrier to the provision of health services.

Health Education

One way to measure the success of Head Start is to understand how children and their families become better prepared to meet the challenges of improving their health and lifestyles after they leave Head Start. This is the goal of Head Start health education. Health education activities include basic hygiene, safety, and other appropriate health behaviors for children, parents, and staff. The major findings of this chapter are summarized below.

"She has made noticeable changes in grooming—combing hair, trying to look nice; I'm brushing more due to her encouragement; tooth brushing is great. She is improving me also."

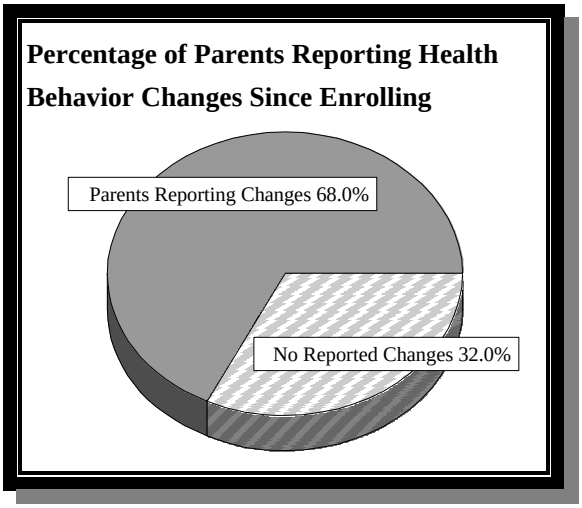
-Head Start parent

- Nutrition, personal hygiene, first aid and safety, and dental health were the most frequently covered classroom health education topics, each being cited by over 85% of the Health Coordinators. Mental Health Coordinators were most likely to list self-esteem and peer relationships as the mental health topics addressed in the classroom curriculum.

- Both the Health and Mental Health Coordinators listed classroom discussions and role playing activities as the classroom activities most often used to incorporate health education into the classroom. Classroom visitors, most often nurses, nutritionists, and dentists, provided education for the children and also served as an important outreach activity by getting community providers involved with the local programs.

- Parent education topics most reported by parents included parenting, child growth and development, and nutrition and meal planning. Nearly all of the programs were reported offering parent classes at least once a month, with a quarter of the programs holding classes at least once a week.

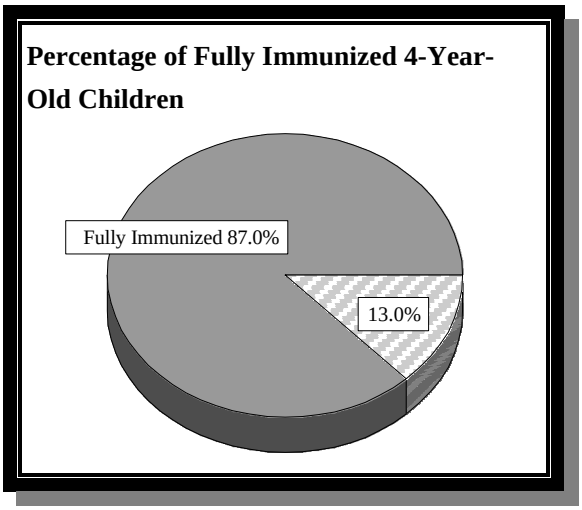
- Almost the entire sample of parents stated that they discussed health topics at home with their children. Changes in either child or adult health behaviors since starting Head Start were noted by two thirds of the parents. Over one quarter of the parents and almost half of the children were described as having some general improvement in their health behavior. Over one tenth (11%) of the parents indicated that their child had acquired attitudes and behaviors in Head Start which have helped change the health behavior of other children or adults in their home.



Immunizations

Under the Program Performance Standards, programs are required to obtain or provide services to assure that age-appropriate immunizations are provided for children before the end of the Head Start year (§ 1304.3-4). The major findings regarding immunizations are summarized below.

- Immunization rates based on the children's health record review showed that over four fifths (87%) of the 4-year-old children were fully immunized in accordance with the Program Information Report (PIR) reporting requirements (4 DPT, 3 OPV, 1 MMR, 1Hib). Recently, the CDC reported that only 75% of preschool children are immunized to this level nationally.



- Children typically received 9 of the 11 required immunizations needed by the time they left the program. The missing immunizations were almost always the final oral polio vaccine (OPV) and the final diphtheria, pertussis, and tetanus (DPT) shots. Immunizations requirements for entry into kindergarten vary by State.

- Parent-held records indicated that 10-15% of the children had additional immunizations that were not noted in the child health files kept at the Head Start Program.

- A majority of the Health Coordinators interviewed were not able to correctly report the Head Start requirements for DPT and OPV vaccinations in effect at the time of the study.

Health Status and Health Services Within the Four Health Domains

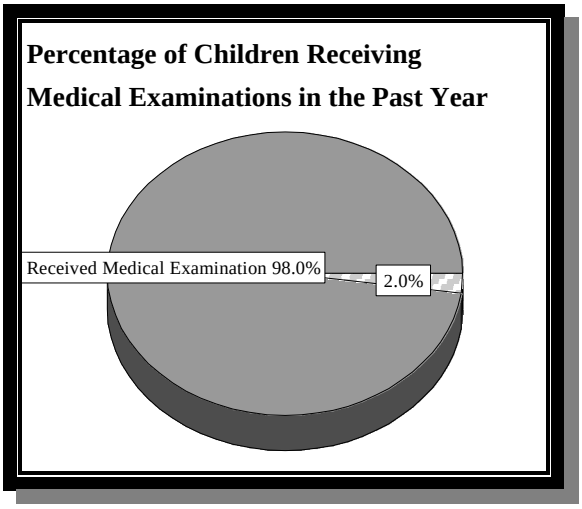
Guidelines under the Program Performance Standards address program activities specifically related to each of the four health domains: medical health, dental health, mental health, and nutrition. These guidelines include procedures for assuring that children receive appropriate screenings and examinations and also receive required treatments as necessary. Health records and parent interviews yielded information on these areas as well as on children's health status across each of the four health domains.

The Medical Health Domain

Head Start staff encounter a wide range of health conditions among children each year. Activities related to the provision of medical screenings and examinations provided or arranged for by Head Start programs were reported. Data from this chapter came from multiple sources (e.g., parents, child health files, and staff). The highlights of the findings are presented below.

"The health check and dental checks would have never been done without Head Start's help."
-Head Start parent

- Parent reports, in conjunction with reviews of the child health files, indicate that over 98% of the Head Start children received physical examinations during the past year. These findings are consistent with those from the annual PIR reports.



- Health conditions requiring follow-up were reported by parents for almost 20% of the children. The health conditions most reported were ear problems, speech and language problems, gastrointestinal

problems, asthma and other lower respiratory problems. No single condition was reported by more than one tenth of the parents.

- Screenings and examinations conducted while children were enrolled in Head Start helped detect several health conditions that were not noted during screenings and examinations conducted prior to Head Start enrollment. Conditions more likely identified after enrollment include speech and language problems, blood disorders, and hernias. Dental problems were also more likely to be detected after Head Start enrollment.

Child Health conditions more likely identified after enrollment:

- **Speech and Language Problems**
- **Blood Disorders**
- **Hernias**
- **Dental Problems**

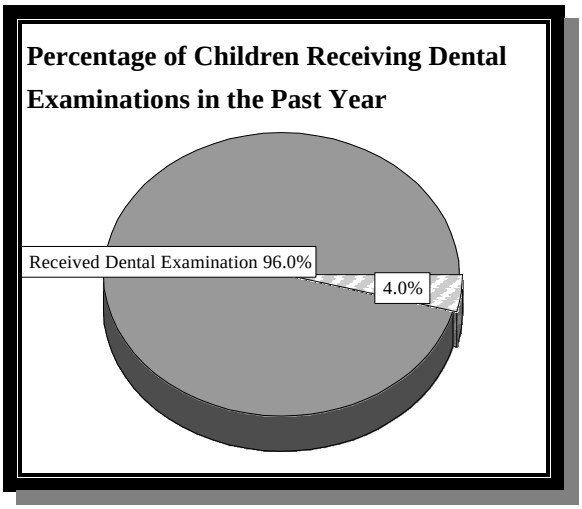
- Over 80% of the health records that reported a health condition requiring treatment contained no documentation on the status of these recommended treatments.

The Dental Health Domain

"I hadn't been able to find a dentist who would take a medical (Medicaid) card."
-Head Start parent

Dental problems are of particular interest to Head Start because of the higher incidence of problems among low-income families and the shortage both of dentists in low-income communities and of dentists willing to accept Medicaid payments. Activities related to the provision of dental screenings and examinations provided or arranged for by Head Start programs were again collected from multiple sources (parents, child health files, and Health Coordinators). The highlights are presented below.

- Overall, parent reports, in conjunction with reviews of child health files, indicate that about 96% of the Head Start children received dental examinations in the past year.



- Almost 42% of the parents reported that their child had an identified dental condition, and over 80% of the identified conditions were dental caries. Only 11% of the health files indicated that a child had a reported dental problem. However, 42% of the child health files had no recording of whether or not the child had dental problems.

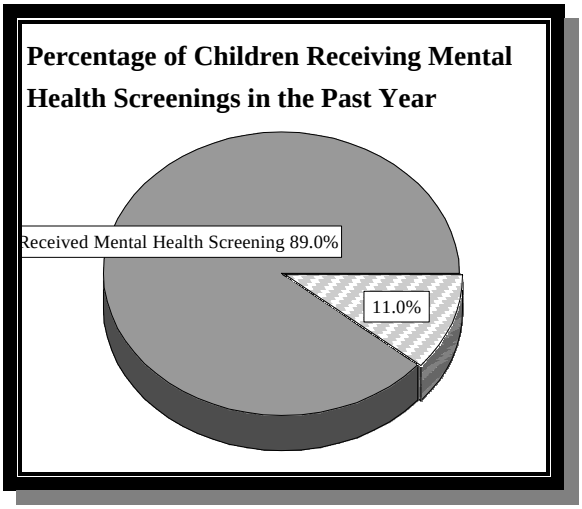
- Based on parents' reports, at least 76% of the conditions had been treated or were currently being treated, while less than 1% of the parents reported not seeking treatment for their children. A significant portion of parents, 24%, did not indicate the treatment status of their children's dental conditions, but this is not necessarily an indication that necessary treatment did not take place or was not scheduled.

The Mental Health Domain

"Thanks to Head Start [she] is able to go the psychologist."
-Head Start parent

Mental health is sometimes overlooked within the Health Component. A number of difficulties were encountered in studying the mental health domain (e.g., definitions and terminology, record keeping practices, confidentiality), making it difficult to paint an accurate picture of the mental health status of Head Start children. The findings that are available are summarized below.

- Almost 90% of the Mental Health Coordinators said that all children in their program are screened for mental health or developmental concerns through observation of classroom or group socialization activities, individual mental health screenings, or both.



- When asking about the mental health of their children, less than 7% of the parents reported that someone from the Head Start center had suggested that their children be evaluated for possible behavior problems.

- Less than 3% of the parents reported that a condition was identified through a developmental assessment. The conditions they were likely to mention were speech and hearing problems, cognitive or developmental delays, or emotional disorders. Many parents listed speech and language concerns under medical problems. Little information was available on the status of treatment.

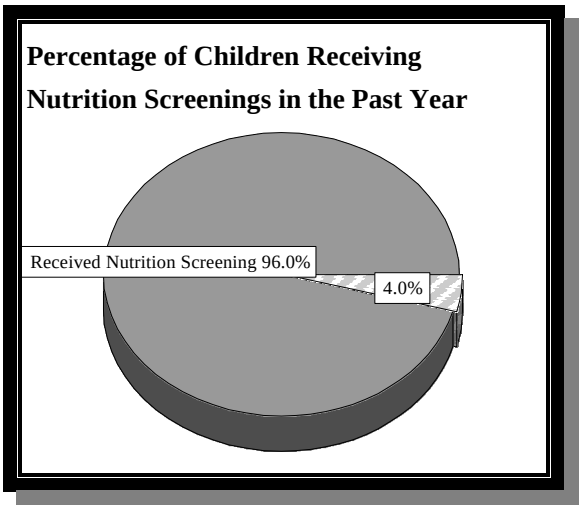
The Nutrition Domain

The nutrition requirements for Head Start programs include preparation of meals which provide children with between one and two thirds of their daily nutritional needs, depending on the length of their school day. Other nutrition activities include the conduct of nutrition screenings provided or arranged for by Head Start programs and educational opportunities for parents on proper nutrition. The highlights of the parent and staff reports are presented below.

"I couldn't make them eat vegetables and fruits. Now she comes home and tells me and her sisters that they have to eat meat, milk, bread, fruit, and vegetables in order to be strong."

-Head Start parent

- About 96% of the children received a nutrition screening during the previous year. Almost 90% of the Nutrition Coordinators reported that children enrolled in their program routinely received individual nutrition screenings.



- Nutrition summaries were available in only a few of the child health files. Approximately 5% of the children were described as being in need of nutrition services. Very few parents (less than 5%) reported their child being obese or underweight as a health condition.

- Meals provided an excellent opportunity for staff to provide nutrition and general health education for children as well as socialization experiences. Healthful activities, such as hand washing, were incorporated into the daily classroom routine surrounding meals.

Study Strengths and Limitations

As a descriptive study, the findings from this project fit a specific need of the Head Start Bureau: objective information on the implementation of the Health Component. To this end, it is recognized that the study has both strengths and weaknesses. A principal strength is that this descriptive study provides a sample that is representative of the overall Head Start population. The stratification plan used for the random sample provides a representative view of the general Head Start population, allowing child-level data to be weighted and national estimates produced.

The use of multiple data sources is an important element of the study. For example, receiving information from Head Start staff, Head Start parents, and child health records was especially useful in clarifying the immunization data. Interviews with staff and parents clearly indicated that immunization rates are higher than reflected in the Head Start records.

The study limitations include the use of Head Start child health files which were not always complete and which often varied in content from program to program. Variations across programs in record-keeping practices made preparation for data collections difficult, and sometimes made specific pieces of information inaccessible to the research staff.

Unfortunately, the data collection was restricted to only one visit per site. Longitudinal data reflecting the impact of specific Health Component activities on the behavior of children and their families would be very useful for staff in determining the distribution of program resources. The research team was also unable to undertake direct health checks on the children or review primary provider or clinic health records to supplement or validate those held by parents or Head Start programs.

Implications for Head Start Program Practices

After visits to 81 centers in 40 programs and completing almost 1,500 interviews with Head Start parents and staff, the picture of the Head Start Health Component is not yet complete, but it is becoming much clearer. The Head Start Bureau has the opportunity to integrate the information from this report into policy initiatives and program support. For example, information gained from this study will be useful to ACYF as it provides support and direction to local Head Start programs' efforts to implement the newly revised Head Start Program Performance Standards. Based on the findings of this study, six areas are discussed here in terms of their implications for the provision of health services within Head Start.

Staff Training and Support. One of the more striking findings on how programs implement the Health Component was the number of Health Coordinators who reported having multiple roles within their program. While comprehensive staff training is crucial to the provision of appropriate care and education for enrolled children, training is even more critical for staff with responsibilities for managing multiple health domains or multiple program components, as staff persons with multiple responsibilities may not have prior training or experience related to each responsibility. This issue may be particularly true for smaller programs with fewer resources for

providing or accessing staff training. Data from the study suggest that component coordinators in smaller Head Start programs have fewer educational credentials, yet are far more likely to perform multiple roles. Program managers should ensure that training activities address the range of backgrounds noted among the staff, and help individuals with multiple roles develop strategies to best manage these responsibilities. Beyond the training of existing staff, the revised Program Performance Standards support the development of consultative relationships with health professionals outside the program to assist center staff in carrying out specific health-related functions.

Immunizations Records and Knowledge. Improvements in record-keeping strategies will help Head Start programs maintain up-to-date information on the immunization status of the children they serve. As noted earlier, between 10-15% of the children had received additional immunizations which were noted on the parent-held records, but were not found in the Head Start records.

Subsequent to the data collection for the present study, the Head Start Bureau updated the immunization requirements for children attending the program and modified the PIR reporting requirements to be consistent with these requirements. Given that the revised Program Performance Standards require programs to follow, at a minimum, the immunization schedule implemented in the Medicaid/EPSDT program in their State, technical assistance regarding the State Medicaid/EPSDT immunization requirements is needed for all health staff, not just the Health Coordinators. In addition, systems to ensure that immunization status and all relevant health information are recorded, reviewed regularly, and kept current during the program year will assure that immunization records are complete as children leave Head Start. Linkages with State health departments and Medicaid will ensure programs access to the most recent State immunization requirements and would promote “best practices.”

Mental Health Issues. Head Start's developmentally appropriate activities for children, and its emphasis on parent involvement, form the foundation of its role in mental health

promotion and primary prevention. However, this study found that most programs' efforts to identify the mental health needs of individual children and to track the provision of services to them, were not well-documented. As suggested by the American Orthopsychiatric Association study of Head Start mental health services (AOA, 1994), programs were reluctant to identify and make referrals for mental health interventions except in the most serious cases, did not keep sufficient records about the interventions which did occur, and preferred describing concerns about children's behavior as developmental/language delay issues rather than as mental health needs. National and local leadership is needed to address Head Start staff and family attitudes which may be limiting the provision of needed mental health services, including: concerns about the perceived stigma attached to children receiving mental health services; reluctance to record information without more certainty about the safeguards for confidentiality; and, a failure to acknowledge the costs of under-reporting mental health concerns or waiting until problem is more serious. In addition to information and training, the Head Start leadership should provide significant direction and support for developing and sustaining responsive mental health services in Head Start programs that can demonstrate more immediately to parents and staff the value of a more systematic approach to mental health intervention. Head Start programs' self-examination of mental health services in light of the revised Program Performance Standards presents a critical opportunity to implement the improvements needed.

Treatment Follow-Up. As part of a comprehensive health program, it is necessary for staff to receive training on the importance of carefully tracking the medical progress of the children they serve. Reviews of the child health files in the present study yielded information that indicate that Head Start children are being properly screened for medical and dental problems; however, the health files contained relatively little documentation about whether treatments actually were completed, in progress, or ongoing, as in the case of chronic health conditions. Over 80% of the health records that reported a health condition had incomplete or no follow-up data on the status of the recommended treatments. This situation does not necessarily mean that treatments are not taking place, because parents' reports indicated a higher percentage of completed treatments. It does suggest, however, that better information is needed to

appropriately document and monitor the status of what happens to Head Start children when medical, dental, mental health, or nutrition screenings indicate the need for treatment services. The tracking procedures required under the revised Program Performance Standards should have a positive impact in this area.

Record Keeping. Continued encouragement and support for efforts such as the Head Start Family Information System (HSFIS) and other automated data collection systems containing similar data elements is needed to help programs standardize the collection of information about the families they serve as well provide a simple, automated system for updating and retrieving information on these families. Record-keeping practices varied greatly across the programs and centers studied. This was particularly true for the fiscal information collected from the Budget Managers. Efforts to expand the systematic and comprehensive tracking of services consistent with the revised Program Performance Standards should improve the comparability of records across centers and programs, provide a consistent basis for national training activities related to record keeping issues, and help ensure appropriate documentation of quality service provision. Key issues in the implementation of the HSFIS or similar systems are the provision of equipment and adequate training to program staff that emphasizes the need for such information from every program.

Collaboration Activities. In an era that will be noted for reforms in welfare and other public assistance programs, local, Tribal, State, and Federal agencies serving low-income families have an increasing need to coordinate their services. The creation of useful community linkages for Head Start is dependent on the active integration of local programs with community and State programs as well as with other Federal resources, such as Medicaid, the United States Department of Agriculture Nutrition Programs (USDA), (e.g., the Women, Infants, and Children program (WIC)), and Temporary Assistance for Needy Families (TANF). This study found evidence through the staff and parent reports that these activities are occurring, making it clear that Head Start does not work as a "stand alone" Federal program. However, a re-emphasis in this area is warranted in light of the revised Program Performance Standards, requiring that

children be linked to a "medical home" where health services are not provided to families by Head Start. Individual Head Start programs must actively pursue partnerships with other Federal, State, Tribal, community and local health agencies so that the combined resources maximize the health services available to children and families while containing costs to local programs.

Recommendations for Future Research

One of the original intentions of this descriptive study was to generate hypotheses and methodological recommendations for future research on both the Health Component and the Head Start program in general. In terms of future research activities, the following suggestions are offered to help guide future studies of the Head Start program:

- **Determining the Impact of the Program on Families.** Head Start parents come to the program with a wide range of skills and knowledge needed to manage the acquisition of health care services for their families. It is necessary to learn what basic, health-related skills and strengths families bring to Head Start and how different these skills are when they leave the program.

- **Staffing Patterns.** The present study revealed a wide variety of staffing patterns that should be explored in subsequent studies in order to assess whether there are specific models of health service delivery that are more effective than others under certain programmatic and community conditions.

- **Investigating Links with Community Services.** It was difficult in this study to determine the level of formality of the Head Start-community links that have been established. It may be necessary to survey community providers to determine, from their perspective, how Head Start serves the community and how these providers work with Head Start families as well as what specific factors appear to contribute to efficient and effective collaborations with Head Start and/or service delivery to Head Start families.

- **Sampling Considerations.** The development of any sampling plan intended to produce appropriate representation of urban and rural programs must take into account the fact that many Head Start programs include centers that serve both types of areas. More detailed information is required on individual Head Start centers and the geographic areas or populations they serve.

- **Instrument Development.** A review of the findings from this study has lead to the conclusion that instrument development activities in future projects must consider the use of multiple data sources in order to understand differences across staff roles and to provide comparisons across sources, including the possibility of gathering data directly from community health providers.

Summary

> **"The program is concerned about the health of the children. They care a lot for the girl and I am very grateful for that."**
>
> ***-Head Start parent***

It appears that, in serving Head Start families, programs engage in three levels of activities: assuring that children get screenings and needed health services, that children receive preventive care, and that both children and families learn to take responsibility for their own health care and health-related behaviors. The Health Component provides the opportunity for all families to benefit through prompt diagnosis and treatment, and by ensuring that the children are as healthy as possible before they enter kindergarten. Not all families need Head Start's assistance in accessing health services. The program is designed so that those in need of assistance receive care, and that these families develop the skills necessary to access appropriate care and develop a "medical home" independent of the Head Start program. These steps are a primary focus of the revisions in the Program Performance Standards.

Clearly, the Health Component is a very valuable and unique piece of the overall Head Start program. It is hoped that the "snapshot" taken by this study will generate useful questions that will drive future research activities. The research team completes this project with both admiration and respect for the Head Start families as well as the local Head Start staff. These individuals work endlessly, often under less than ideal conditions, to improve the lives of the children in local programs. We hope that the information gathered during this study will directly benefit their work.

"I love Head Start—This is my third child in Head Start. It is the best program available for children."
-Head Start parent

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1.0 INTRODUCTION

"I love Head Start. It is the best program available for children. "

Head Start Parent

Founded in 1965, the Head Start program offers comprehensive services including early education, nutrition, health, and social services, along with a strong parent involvement focus, to low-income children nationwide. Its overall goal is to bring about a greater degree of social competence, which is defined as a child's everyday effectiveness in dealing with both his or her present environment and later responsibilities in school and life, taking into account the interrelatedness of cognitive, intellectual, and social development; physical and mental health; and nutritional needs.

Head Start programs are funded through a direct Federal-to-local relationship, and include a wide range of programs that are community based, so they can respond to local needs and coordinate activities with other community agencies. They are guided by a set of Program Performance Standards that specify requirements in each of the functional areas, including disabilities.

The Head Start Bureau within the Administration on Children, Youth and Families (ACYF) in the Administration for Children (ACF), U.S. Department of Health and Human Services, (DHHS) has responsibility for oversight and leadership of Head Start programs nationwide. It also funds special initiatives, and develops legislative and budget proposals for programs. Local ACYF oversight is provided by 12 Regional Offices, which conduct compliance reviews of local programs every three years.

During fiscal year 1994, the year in which study data for this report were collected, Head Start served an estimated 740,000 children and their families in almost 2,000 programs nationwide. The FY 1994 budget was $3.3 billion (General Accounting Office, 1994).

In 1993, with an eye toward the future of Head Start, the Advisory Committee on Head Start Quality and Expansion issued a document, *Creating a 21st Century Head Start: Final Report of the Advisory Committee on Head Start Quality and Expansion* (1993), which made recommendations for Head Start as the program prepares for the next century. The report recommended 1) improving Head Start staff training in order to increase the quality of the services provided, and expansions in the numbers of children served and the range of services provided to Head Start children and their families; 2) improving community partnerships to more effectively meet the needs of Head Start families in the areas of family support, health, and education; and 3) strengthening Federal oversight of Head Start. The collection of reliable and valid baseline information on the Health Component will assist Federal staff in accurately identifying program needs.

Also in 1993, DHHS' Office of the Inspector General (OIG) focused attention on Head Start by issuing a report on the implementation of expansion funds entitled *Evaluating Head Start Expansion Through Performance Indicators* (OIG, 1993). This study covered many aspects of Head Start, including the Health Component. The policy analyses of the Advisory Committee and the OIG share at least one common conclusion: that additional baseline data from children's Head Start records, parent interviews, and staff interviews are needed to increase understanding of the health problems and service needs of Head Start children and their families.

The descriptive findings presented in this report are one step in a long-term research strategy to meet these program needs. They also provide data critical for implementing many of the Advisory Committee's recommendations. This study goes beyond the usual compilation of Head Start child health records and standard data from the Head Start Program

Information Report (PIR). It includes interviews with Head Start parents about how the program helps them obtain health services for their families, and with Head Start staff about the operation of the Health Component. The study results are based upon reports from a nationally representative sample of 1,189 families with 4-year-old children enrolled in 40 Head Start programs spread across the nation. This broad description of the Health Component is an important element of the Head Start Bureau's database on programs and children.

1.1 Research Questions

The purpose of this study is to describe the Head Start Health Component across the four health domains: medical, dental, nutrition, and mental health. The program elements described include:

- Head Start staffing patterns and prior and ongoing staff training and experience related to the Health Component;
- Utilization of community resources in the provision of health services;
- Barriers to the provision of health services for Head Start families and programs;
- Current preventive health efforts provided for children and parents; and
- Current screening, examination, referral, treatment, and follow-up procedures employed in each health domain.

Based on these elements, research questions were developed to drive the data collection effort.

1.2 Study Overview

The ACYF contracted with The CDM Group, Inc. (CDM) and its subcontractor Abt Associates, Inc. (Abt) to undertake this two-phase study. During **Phase I**, the research team designed the study, convened a Technical Advisory Panel, developed the necessary data collection instruments and plans, devised a study sample selection plan, and completed an Office of Management and Budget (OMB) clearance package. **Phase II** consisted of a pilot test, data collection, coding of the qualitative data, data analysis, and report preparation. The timeframe for data collection was April through June, 1994, assuring that all data would be collected before the children left Head Start to enter kindergarten.

The study design called for a sample of 40 Head Start programs. For each selected program, two centers were to be randomly chosen as target sites, for an expected total of 80 Head Start centers.[1] The goal of the research team was to interview program and center staff associated with the operation of the Health Component. At each center, an additional goal was to interview the parents of 15 randomly selected 4-year-old children and to review the Head Start health records for these children.

The research staff obtained information from nine primary data sources: Parents, Head Start child health records, meal observations at Head Start centers, Center Directors (or Lead Teachers), Health Coordinators, Mental Health Coordinators, Parent Involvement Coordinators, Nutrition Coordinators, and Budget Managers. The study was designed to take advantage of multiple sources of information regarding the health status of the children. In this way, the Head Start health records could be supplemented by parents' reports on the same information.

[1] In practice, one of the programs selected was entirely home-based and one had only a single center. Other selected centers were too small to support the intended sample, so additional centers were selected for three programs. A final set of 81 centers participated in the study (see Chapter 3: Methodology).

1.3 Organization of the Report

This report is organized into four volumes. Volume I contains the Executive Summary and a longer summary of the study findings. Volume II is a technical report with a detailed outline of the study methodology, including sampling and data collection methods. Volume II also includes eight chapters related to the study findings, a summary chapter, and the Executive Summary. The chapter structures of Volumes I and II are the same, facilitating the reader's ability to move from one volume to the other when more detailed or technical information is desired.

Volume III presents a summary of the qualitative data not included in Volume II. The qualitative data include follow-up interviews with the research associates who supervised the individual site visits and the detailed information that was summarized in Volumes I and II. It also includes several categories of responses from Head Start staff and parents to open-ended questions that are not summarized in the other volumes. Volume IV is the Appendices and contains the consent form, a summary of the relationship between the research questions and the data collection instruments, the data collection instruments, and a literature review.